



# **Washington State Hepatitis C Strategic Plan**

January 2004



*Information Summary and Recommendations*

# **Hepatitis C Strategic Plan**

January 2004



For more information or additional  
copies of this report, contact:

Wendy Krier, Hepatitis C Coordinator  
Infectious Disease and Reproductive Health  
PO Box 47838  
Olympia, Washington 98504-7838

Phone: (360) 236-3440  
Fax: (360) 586-5440  
E-mail: [WAHepC@doh.wa.gov](mailto:WAHepC@doh.wa.gov)

Mary C. Selecky  
Secretary of Health

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STATE OF WASHINGTON  
DEPARTMENT OF HEALTH  
*Olympia, Washington 98504*

January 2, 2004

Dear Colleague:

We are pleased to present the Washington State Hepatitis C Strategic Plan for the education, prevention and management of hepatitis C (HCV). This report responds to Substitute Senate Bill 5039 (Appendix A), which was passed during the 2003 legislative session. This plan would not have been possible without a group of experts and dedicated activists who assisted the Department of Health in the development of the plan. The Advisory Committee members donated many hours of their valuable time, making the completion of the plan possible. We acknowledge their efforts with much appreciation.

Hepatitis C is emerging as one of our state's major public health problems. Chronic HCV infection has been a reportable condition in Washington State since December 2000. Currently there are over 10,000 reported cases statewide, and it is estimated that as many as 100,000 people may be infected. Continuous surveillance efforts are being made to help us gain a more accurate understanding of the HCV epidemic in Washington State.

The realization of this Strategic Plan will help Washington achieve a more accurate picture of the incidence and prevalence of disease, broader testing availability, further development of medical referral, and a broader dissemination of accurate information.

The effects of HCV are too great to ignore. It is the goal of The Department of Health and its partners that this plan be implemented through collaborations with community partners. The resources needed to educate, prevent, and manage care will need to be sought within the current health system. The cost benefit of prevention, like so many infectious diseases, is clear.

Please take these recommendations and share them with providers, health care networks, susceptible individuals, educators, parents and others. The challenge of successfully changing the course of the HCV epidemic will depend on how well these and other interventions are promoted within our state.

Sincerely,

A handwritten signature in black ink, reading "Mary C. Selecky".

Mary C. Selecky  
Secretary

# Executive Summary

## **Introduction**

Hepatitis C is the most common blood-borne infection in the United States. It is estimated that 3.9 million people (1.8% of the population of the U.S.) are infected with the hepatitis C virus (HCV), and of these individuals, 2.7 million are chronically infected. HCV infection can lead to cirrhosis and liver cancer. It is the most common cause, after alcohol, of chronic liver disease. Each year an estimated 8,000 to 10,000 individuals die as a result of chronic liver disease. HCV is the most frequent reason in the U.S. for a liver transplant.

According to the Centers for Disease Control and Prevention (CDC), risk factors for HCV include contact with blood or body fluids from a person infected with HCV. This exposure can occur from injecting illegal drugs (even if only once many years ago), blood transfusions or solid organ transplants before July 1992, receipt of clotting factor(s) made before 1987, and long-term kidney dialysis. HCV can also be passed from an infected mother to her baby during birth.

In this document, the term **high-risk** is used to define groups and individuals who will be the target of specific HCV education, prevention, and management efforts. National and statewide data are used to identify populations at high-risk for HCV.

According to CDC data, the highest prevalence and risk of infection is found among those with large or repeated direct percutaneous exposures to blood (e.g., injecting-drug users, persons with hemophilia who were treated with clotting factor concentrates produced before 1987, and recipients of transfusions from HCV-positive donors). Moderate prevalence and risk is found among those with frequent but smaller direct percutaneous exposures (e.g., long-term hemodialysis patients). Lower prevalence and risk is found among those with inapparent percutaneous or mucosal exposures (e.g., persons with evidence of high-risk sexual practices) or among those with small, sporadic percutaneous exposures (e.g., health-care workers). The lowest prevalence and risk of HCV infection is found among those with no risk characteristics (e.g., volunteer blood donors). For purposes of this document, those with lowest prevalence or lowest risk are referred to as the general population in education, prevention and management recommendations.

## **Legislative Background**

In May 2003, Governor Gary Locke signed Substitute Senate Bill 5039 (SSB 5039). This legislation mandated the Secretary of Health to create a state plan for the education, prevention, and management of the hepatitis C virus (HCV) in Washington State.

SSB 5039 served as a guide to the Department of Health (DOH) in the planning and development of a statewide Strategic Plan to address HCV in Washington. The legislation outlined stakeholder groups to be consulted in the planning process, as well as target populations and educational areas to be addressed.

Due to the budget constraints within the state of Washington, SSB 5039 did not appropriate any state funds for the development or implementation of a state Strategic Plan. Implementation of the plan is dependent on availability of federal and private funds, or future appropriation of state funds by the Washington State Legislature.

While DOH and its partners will need to solicit federal and private funds in order to implement this plan, sustained state funds are needed to develop and maintain a collaborative, successful hepatitis C Program in Washington State.

## **Goals and Objectives**

An Advisory Committee of 34 key stakeholders and community members was convened to assist DOH with the development of a Strategic Plan. The Advisory Committee was divided into four workgroups to address education, prevention, management, and funding as outlined in the legislation for implementation of the plan. Each workgroup designated a chair and then identified one governing goal.

In preparation for the strategic planning process, DOH reviewed several HCV Strategic Plans from other states, including California, Texas, and Hawaii. In addition, DOH staff traveled to Florida and Wisconsin to gain a better understanding of the planning processes and implementation strategies used. Through the review of various plans, coupled with collaboration with public health staff from those states, DOH created a matrix for the Advisory Committee of strategic initiatives. The Advisory Committee referenced the matrix of work currently being done in other states to develop a set of objectives and action steps appropriate to address HCV in Washington State. DOH will continue to collaborate with other states to gain insight into plan implementation and disease management.

The goals and objectives for each workgroup are as follows:

### **Education**

<b>Goal:</b>	Provide education and training in HCV for health care professionals, policymakers, high-risk populations, HCV infected people and the general public, including those in schools.
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Objective 1: Provide HCV education and training for licensed health and health-related professionals.

Objective 2: Provide education and information about the HCV epidemic to

policymakers.

Objective 3: Provide a comprehensive public awareness and education campaign.

Objective 4: Develop and implement a targeted statewide media campaign to increase awareness and provide risk reduction information about HCV.

### **Prevention**

<b>Goal:</b>	Significantly decrease the number of people newly infected with HCV using the most effective prevention strategies.
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Objective 1: Improve the state and local health department surveillance system to increase and enhance knowledge of HCV incidence and prevalence in Washington.

Objective 2: Integrate HCV education, counseling, testing and referral into existing relevant programs that serve high-risk and other vulnerable populations.

Objective 3: Develop alternative sources for the delivery of HCV primary prevention services for high-risk populations not served by HIV/AIDS, STD, and substance abuse programs.

Objective 4: Strengthen collaboration among state agencies; and between state and local governmental agencies and private sector stakeholders to prevent the spread of HCV.

Objective 5: Evaluate the effectiveness of HCV prevention programs.

### **Management**

<b>Goal:</b>	Identify effective, accessible, and affordable case management and treatment services to prevent or limit the progression and complications of HCV infection and improve the affected individual's quality of life.
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Objective 1: Establish and implement a comprehensive care structure for the management of HCV. This structure should include HCV testing, treatment, disease management, patient education, and referrals to substance abuse treatment (including methadone treatment centers) and other related services for all high-risk individuals receiving services through local drug treatment and needle exchange programs, HIV/AIDS/STD programs, local health departments, correctional settings,

veteran services, community health, mental health, and/or other relevant agencies.

- Objective 2: Offer education and training opportunities on long-term clinical management of HCV to physicians, nurse practitioners, registered nurses and allied health professionals.
- Objective 3: Offer patients and their families education (prevention, management and transmission) about living with HCV.
- Objective 4: Assure continuity of care for HCV patients who are transitioning between incarceration and the community.
- Objective 5: Research and identify a comprehensive model for an evidence-based process for prevention and management of HCV that is based on existing national recommendations and guidelines.

### **Funding**

<b>Goal:</b>	Develop strategies for providing adequate, sustainable resources for funding the implementation and maintenance of Washington State Hepatitis C Strategic Plan recommendations developed by the Advisory Committee.
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- Objective 1: Utilize existing resources to establish a framework to implement the elements of the plan that can be funded within those existing resources.
- Objective 2: Identify and pursue options for in-kind donations, services, and materials from private and public sources.
- Objective 3: Identify and pursue public (local, state and/or federal) grant and funding opportunities.
- Objective 4: Identify and pursue potential funding from both hepatitis specific and non-hepatitis specific private foundations / organizations.

### **Timeline**

From each objective, a series of action steps was developed. The action steps were prioritized using a three-year implementation plan, designated to begin on January 1, 2004.

SSB 5039 mandates DOH to provide the legislature with an update and progress report for the state Strategic Plan on December 1, 2004, and biennially thereafter.

## **Future Collaboration**

The majority of the Advisory Committee’s “recommendations” depend on the ability of the Department of Health to facilitate the “action steps”. The success of this plan will involve a coordinated, collaborative and sustained approach for the prevention, education and management of HCV by many sectors around the state. Partnerships between DOH and stakeholder groups, including those who helped to develop this plan, will be necessary to fully implement this plan.

## **Acknowledgements/Strategic Planning Process**

The development of the strategic plan to address HCV in Washington State is credited largely to an Advisory Committee of 34 stakeholders and community members convened by the Department of Health (DOH). Each participant brought a wealth of knowledge and experience to the planning process and the success of this planning process is owed to their hard work and dedication.

Stakeholder groups represented by the Advisory Committee included several local health departments, various patient/advocacy groups from around the state, research organizations, public health and clinical laboratory staff, relevant state agencies, state health care associations, providers/suppliers of HCV services, public members, the University of Washington, and the primary sponsors of the bill from the Washington State Legislature, Senator Jim Kastama and Representative Shay Schual-Berke.

Three full day Advisory Committee meetings were held in Seattle, Washington. Co-chairs were nominated to lead the group and serve as liaisons between the Advisory Committee and DOH. Meeting facilitation was provided by The Paragon Consulting Group, LLC.

The group developed mission and vision statements for the Strategic Plan. The larger committee was then divided into four workgroups to address key pieces of the legislation governing the strategic planning process (SSB 5039). The four workgroups addressed: Education, Prevention, Management, and Funding. A chair was identified for each workgroup, which met several times independent of the Advisory Committee. Additional stakeholders and subject experts were added to the workgroups, as deemed necessary.

In preparation for the strategic planning process, DOH reviewed several HCV Strategic Plans from other states, including California, Texas, and Hawaii. In addition, DOH staff traveled to Florida and Wisconsin to gain a better understanding of the planning processes and plan implementation strategies used. Through collaboration with public health staff from those states, DOH created a matrix of strategic initiatives for the Advisory Committee.

The matrix of work being done in other states served as a resource to each workgroup as they developed a list of recommended objectives and action steps appropriate to address HCV in Washington State. The list of recommendations was prioritized using a three-year implementation plan. In the final meeting of the full Advisory Committee, all workgroup recommendations were discussed and adopted. The Advisory Committee's recommendations were incorporated into the final DOH Strategic Plan.

## Strategic Planning Advisory Committee Members

*Mary Saffold*  
Tacoma-Pierce County Health Department

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*Dr. Bob Wood*  
Public Health-Seattle/King County

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*Ted Rail*  
Washington State Council of Firefighters

---

*Dr. Jeff Duchin*  
Public Health-Seattle/King County

---

*Kitty Candelaria*  
National Hepatitis C Institute

---

*Sandra Randels*  
Public Health-Seattle/King County

---

*Michael Ninburg, Advisory Committee Co-Chair\*\**  
Hepatitis C Education Project

---

*Susie Tracy*  
Washington State Medical Association

---

*Teresa Hanbey*  
Hepatitis C Outreach Project

---

*Beverly Simmons*  
Washington State Hospital Association

---

*Jan Hicks-Thomson*  
Washington State Department of Health

---

*Pamela Tollefsen*  
Office of the Superintendent of Public Instruction

---

*Barbara Hernandez*  
Pacific Northwest Chapter  
American Liver Foundation

---

*Pamela Sacks, Advisory Committee Co-Chair\*\**  
Division of Alcohol and Substance Abuse  
Department of Social and Health Services

---

*Dr. Robert Carithers*  
Hepatology Clinic  
University of Washington Medical Center

---

*Suzanne Mager*  
Washington State Department of Labor and  
Industries

---

*Paula Cox*  
Hepatology Clinic  
University of Washington Medical Center

---

*Alfie Alvarado*  
Washington State Department of Veteran's  
Affairs

---

*Beth Anderson*  
Washington State Department of Corrections

---

*Leslie Franz*  
Public Member

---

*Dr. Marc Stern*  
Washington State Department of Corrections

---

*Ane Kunga Palmo*  
Frontline Hepatitis Awareness

---

*Cindy Jobb*  
Spokane Regional Health District

---

*Senator Jim Kastama*  
Washington State Senate

---

*Dr. Jo Hofmann*  
Washington State Department of Health

---

*Representative Shay Schual-Berke*  
Washington State House of Representatives

---

*Eileen Sullivan*  
Roche

---

*Scott Sigmon*  
Schering-Plough

---

*Melissa Davis*  
Schering-Plough

---

*Jim Peterson*  
Quest Diagnostics Laboratory

---

*John Davison*  
Department of Medicine  
University of Washington

---

*Dr. Jason Dominitz*  
Department of Medicine  
University of Washington

---

*Dr. Russ Alexander*  
Hepatitis Education Project Medical Advisory  
School of Public Health  
University of Washington

---

*Dr. Jinxin Hu*  
Public Health Laboratory  
Washington State Department of Health

---

## **STAFF**

*Wendy Krier*  
Hepatitis C Coordinator  
Washington State Department of Health

---

*Marge Mohoric*  
Meeting Facilitator  
The Paragon Consulting Group, LLC

---

*Maria Courogen*  
Assessment Unit Manager  
Epidemiologist, IDRH  
Washington State Department of Health

---

*Jack Jourden*  
Director  
Infectious Disease and Reproductive Health  
Washington State Department of Health

---

## Education Workgroup Members

*Kitty Candelaria, Education Workgroup Chair\*\**  
National Hepatitis C Institute

---

*Sandra Randels*  
Public Health-Seattle/King County

---

*Michael Ninburg, Advisory Committee Co-Chair\*\**  
Hepatitis Education Project

---

*Scott Sigman*  
Schering-Plough

---

*Ane Kunga Palmo*  
Frontline Hepatitis Awareness

---

*Susie Tracy*  
Washington State Medical Association

---

*John Davison*  
Department of Medicine  
University of Washington

---

*Paula Cox*  
Hepatology Clinic  
University of Washington Medical Center

---

*Beverly Simmons*  
Washington State Hospital Association

---

*Ted Rail*  
Washington State Council of Firefighters

---

*Eileen Sullivan*  
Roche

---

*Teresa Hanbey*  
Hepatitis C Outreach Project

---

*Dr. Jo Hofmann*  
Public Health Laboratory  
Washington State Department of Health

---

*Barbara Hernandez*  
Pacific Northwest Chapter  
American Liver Foundation

---

*Pamela Tollefsen*  
Office of the Superintendent of Public Instruction

---

*Steve Graham*  
Hepatitis Education Project

---

*Mary Van Bronkhorst*  
Harborview Medical Center

---

## Management Workgroup Members

*Jim Peterson, Management Workgroup Chair\*\**  
Quest Diagnostics Incorporated

---

*Dr. Leanna Standish*  
Bastyr University

---

*Pamela Sacks, Advisory Committee Co-Chair\*\**  
Division of Alcohol and Substance Abuse  
Washington State Department of Social and Health  
Services

---

*Dr. Robert Carithers*  
Hepatology Clinic  
University of Washington Medical Center

---

*Dr. Bob Wood*  
Public Health-Seattle/King County

---

*Dr. Robert Barnes*  
Virginia Mason Medical Center

---

*Dr. Jeff Duchin*  
Public Health-Seattle/King County

---

*Dr. Jinxin Hu*  
Washington State Department of Health

---

*John Hodgkin*  
Public Member

---

*Jamie Lifka*  
Washington State Labor and Industries

---

*Mary Saffold*  
Tacoma- Pierce County Health Department

---

*Melissa Davis*  
Schering-Plough

---

*Dr. Marc Stern*  
Washington State Department of Corrections

---

*Teresa Hanbey*  
Hepatitis C Outreach Project

---

*Dr. Marcia Goldoft*  
Public Health Laboratory  
Washington State Department of Health

---

## Prevention Workgroup

*Dr. Russ Alexander, Prevention Workgroup Chair\*\**  
Hepatitis Education Project Medical Advisory  
School of Public Health  
University of Washington

---

*Beth Anderson*  
Washington State Department of Corrections

---

*Pamela Sacks, Advisory Committee Co-Chair\*\**  
Division of Alcohol and Substance Abuse  
Washington State Department of Social and Health  
Services

---

*Barbara Hernandez*  
Pacific Northwest Chapter  
American Liver Foundation

---

*Cindy Jobb*  
Spokane Regional Health District

---

*Maria Courogen*  
Washington State Department of Health

---

*Tom Jaenicke*  
Washington State Department of Health

---

*Leslie Franz*  
Public Member

---

*Anna Easton*  
Washington State Department of Health

---

*Jan Hicks-Thomson*  
Washington State Department of Health

---

*John Furman*  
Washington State Department of Labor and  
Industries

---

## Funding Workgroup

*Jan Hicks-Thomson, Funding Workgroup Chair\*\**  
Washington State Department of Health

---

*Kitty Candelaria*  
National Hepatitis C Institute

---

*Michael Ninburg, Advisory Committee Co-Chair\*\**  
Hepatitis Education Project

---

*Alfie Alvarado*  
Washington State Department of Veteran's Affairs

---

*Barbara Hernandez*  
Pacific Northwest Chapter  
American Liver Foundation

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## **Mission/Vision Statement**

### **Mission Statement:**

To protect and improve the health of people in Washington State by decreasing the transmission of hepatitis C through education, public awareness, prevention and management.

### **Vision Statement:**

To develop a coordinated, collaborative, sustainable approach to hepatitis C education, prevention, and management. The following principles will apply:

- ❖ Affordable and accessible HCV services should be available to all persons in need
- ❖ Awareness and education will be available for all
- ❖ Enhanced training will be available for providers
- ❖ Transmission of HCV and related morbidity and mortality will be decreased
- ❖ Measures based on “best practices” for prevention and management of HCV will be identified and promoted

## Washington HCV Data

In Washington State, an estimated 100,000 people may be infected with HCV. Of these, approximately 70,000 will develop chronic infection. Approximately 15,000 may develop cirrhosis within 20 years and as many as 1,000 may develop liver cancer within 20 years. About 250 deaths occur each year as a result of hepatitis C infection.

In Washington State, chronic HCV infection has been a reportable condition since December 2000. Washington Administrative Code (WAC) 246-101 requires that chronic HCV infection be reported by health care providers and health care facilities, on a monthly basis, to local health departments, which send the information on to the Washington State Department of Health. There are exceptions to this practice; Pierce County, as a sentinel hepatitis site, has had laboratory-based reporting of HCV infection to the Tacoma-Pierce County Health Department since 1992.

Between December 2000 and July 2003, a total of 10,823 cases of HCV were reported to public health in Washington State. Providers, health care facilities, and local health departments/jurisdictions reported 7,171 cases of chronic HCV to the Washington State Department of Health. An additional 3,652 were reported via the laboratory-based reporting system to the Tacoma-Pierce County Health Department. These numbers represent a minimum estimate for the following reasons:

- HCV infection surveillance reports may not be representative of all persons infected with HCV infection since it is likely that not all infected persons have been tested.
- Surveillance activities differ among health care providers and facilities, and reporting practices differ from county to county in Washington State. Consequently, positive HCV test results that are not reported to the health department are not included in these numbers.
- Since most HCV-infected persons are asymptomatic and diagnosis is made on the basis of laboratory test results, laboratory reporting is the most efficient way to identify those who are infected. However, reporting by laboratories is not included in WAC 246-101, so laboratory reporting is very limited in Washington State.

In Washington, reported cases of HCV infection are classified as confirmed or unconfirmed. A case is unconfirmed if it has an anti-HCV by EIA (repeatedly reactive) without verification by a more specific test. A case is confirmed if it has one of the following:

- Positive recombinant immunoblot assay (RIBA)
- Polymerase chain reaction (PCR) test result
- Detectable viral load (qualitative or quantitative)

Given these definitions, the 10,823 cases described for Washington State include both confirmed (48%) and unconfirmed (52%) cases of HCV infection.

## **Characteristics of those who are infected with HCV**

In addition to describing the magnitude of the epidemic by estimating/enumerating the number of people infected, it is important to also describe the characteristics of those who are infected in order to better target prevention activities as well as direct resources to the epidemic. Individuals with HCV may be described in terms of how they became infected with HCV, as well as by their sociodemographic characteristics.

HCV is spread by exposure to infected blood or contaminated injection equipment. Before 1992, contaminated transfusions or blood products most commonly spread HCV. Since 1992, all blood products are screened for HCV, so cases due to this exposure mode have dropped dramatically. Currently, the most common way HCV is spread is by sharing of injection drug use equipment. Less common modes of exposure include occupational exposure to blood or mother-to-infant transmission at or near the time of birth.

National data show that persons who received transplants, transfusions or other blood products (including clotting factors for hemophilia) before July 1992 account for about 80% of current chronic HCV infection. However, when considering current risk factors for HCV infection, the largest proportion of cases (60%) is due to injection drug use. Cases due to sexual contact comprise approximately 20% of new cases, and studies have shown that high numbers of sexual partners and presence of sexually transmitted diseases may contribute to this mode of transmission. Cases with no recognized source of infection make up 10% of cases, and cases due to occupational exposure, hemodialysis, transfusion, household contact, and perinatal exposure comprise an additional 10% of cases.

Studies continue to be conducted on other identifiable modes of exposure. For instance, some studies have found an association between tattooing and HCV infection in select populations. At this time, results from these studies can not be generalized to the whole population. CDC is currently conducting a large study to evaluate tattooing as a potential risk, taking into account all exposure risks of the populations being studied as well as the settings in which these exposures occur.

In Washington State, an attempt to collect exposure risk information has been made for the 7,171 cases reported by providers and health care facilities to the Washington State Department of Health. One disadvantage of a laboratory-based reporting system, such as Pierce County's, is that risk information is not collected. Even with a provider-based reporting system, risk is often missing on the case reports. Of the 7,171 cases reported through July 2003, 32% were missing risk information. The most frequently reported mode of exposure was injection drug use (40%). Receipt of blood products/factor concentrates/hemodialysis accounted for 5% of cases, occupational exposure accounted for 1% of cases, sexual exposure accounted for 6% of cases, mother-infant exposure accounted for 1% of cases, and "other risk" (which included other drug use and tattooing) accounted for 16% of cases.

In regards to the sociodemographic characteristics of those reported with chronic HCV, information on gender and age of diagnosis was available for all 10,823 cases. The majority of cases were male (63%) and diagnosed between the ages of 40 and 49 (40%). Race/ethnicity

information was missing for the lab-reported cases (n=3,652), and ethnicity information was left blank on many of the reports from providers (49%). Race was unknown or missing for 33% of cases reported by providers (n=7,171); 47% of cases were white, 7% were African American, 4% were American Indian/Alaska Native, 1% were Asian/Native Hawaiian/Pacific Islander, and 5% were other.

# **IMPLEMENTATION RECOMMENDATIONS**

**As developed by the  
Washington State  
HCV Strategic Planning  
Advisory Committee**

## **The Recommendations**

The Washington State HCV Strategic Planning Advisory Committee, in collaboration with the Washington State Department of Health, developed the following goals, objectives, and action steps.

When developing the objectives and action steps within this plan, the Advisory Committee used a framework called SMART: specific, measurable, action-oriented, realistic, and time-bound. Several action steps contained within the plan include a specific component to evaluate the effectiveness of certain efforts. It is the intent of DOH to develop measures for effectiveness for each objective and action step during the three-year implementation phase.

SSB 5039 states that the recommended objectives and action steps shall be implemented only to the extent that, and for as long as, federal or private funds are available for that purpose, including grants.

While DOH intends to solicit federal and private funds in order to implement this plan, sustained state funds are needed to develop and maintain a collaborative, successful hepatitis C Program in Washington State. The goal of the Department of Health, as well as the many stakeholder organizations that assisted in the plan development, is to see this plan fully implemented. In addition, the resources needed to educate, prevent, and manage care should be sought within the current state health system.

## **Education**

<b>Goal:</b>	Provide education and training in HCV for health care professionals, policymakers, high-risk populations, HCV infected people and the general public, including those in schools.
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**Objective 1:            Provide HCV education and training for licensed health and health related professionals.**

**Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Identify and utilize existing educational resources and infrastructures.

*During years one and two, DOH and its partners should collaborate to:*

2. Develop HCV educational materials for licensed health and health related professionals covered under the Uniform Disciplinary Act (UDA) as necessary. Please see Appendix B for a list of UDA professionals.
3. Develop HCV educational materials for professionals not covered by the UDA as necessary.

**Objective 2:            Provide education and information about the HCV epidemic to policymakers.**

**Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Identify list of key policymakers.
2. Compile appropriate information to disseminate to policymakers, including estimated costs for initial plan implementation and continuing implementation efforts.
3. Identify an on-going vehicle and schedule to disseminate information to policymakers.

**Objective 3:            Provide a comprehensive public awareness and education campaign.**

**Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Identify existing public awareness and education resources and infrastructures.
2. Utilize existing resources and infrastructures to define the educational messages to be delivered and the means of delivery.
3. Collaborate with the Office of the Superintendent of Public Instruction (OSPI), the Parent/Teacher Association (PTA), and school boards to determine how best to integrate HCV education into current curricula.
4. Collaborate with Labor and Industries (L&I) to ensure that HCV information is included in appropriate L&I materials, such as employee and employer information packets and posters. This information should be targeted towards, but not limited to, law enforcement professionals and first responders.

*During years one and two, DOH and its partners should collaborate to:*

5. Develop and integrate current and medically accurate HCV education into existing community-based organizations, treatment centers, correctional facilities and public health programs which includes needle exchange and methadone programs.

*During year two, DOH and its partners should collaborate to:*

6. Collaborate with OSPI, PTA, and school boards to implement HCV education into current school curricula.
7. Develop evaluation criteria for the effectiveness of the public awareness and education campaign.

*During years two and three, DOH and its partners should collaborate to:*

8. Use appropriate health education techniques and strategies to deliver the educational messages to target populations.
9. Evaluate the effectiveness of the public awareness and education campaign.

**Objective 4: Develop and implement a targeted statewide media campaign to increase awareness and provide risk reduction information about HCV.**

#### **Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Identify existing resources and research media campaigns, including those from other states to determine how they may be tailored to address Washington State's HCV needs.
2. Convene a media advisory group for the planning and implementation of a targeted media campaign. This group will also assist in developing evaluation criteria for the effectiveness of the campaign.

*During year two, DOH and its partners should collaborate to:*

3. Develop targeted social marketing, public relations and advertising strategies using the best resources, infrastructures and epidemiological information available.
4. Implement the targeted statewide media campaign.

*During year three, DOH and its partners should collaborate to:*

5. Evaluate the effectiveness of the targeted statewide media campaign.

## **Prevention**

<b>Goal:</b>	Significantly decrease the number of people newly infected with HCV using the most effective prevention strategies.
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**Objective 1:**           **Improve the state and local health department surveillance system to increase and enhance knowledge of HCV incidence and prevalence in Washington.**

### **Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Collaborate with the Washington State Medical Association (WSMA) and other relevant organizations to train and educate health care providers and local health department staff to improve HCV detection and reporting. Training should include guidance for uniform completion of death certificates to reflect HCV as underlying cause of death when applicable.
2. Assemble preliminary HCV surveillance data analyses into summary reports to utilize for targeting prevention activities, as well as for identifying subsequent steps to be taken to strengthen data.

*During years two and three, DOH and its partners should collaborate to:*

3. Develop and adopt a process for more convenient and accurate supplemental reporting from laboratory sources. Note: this will necessitate changes in the Washington Administrative Code (WAC).
4. Develop and adopt a process for more convenient and accurate mechanisms for reporting (e.g. electronic reporting and data transfer mechanisms).
5. After epidemiologic analysis, make surveillance data widely and easily accessible on a regular basis in order to educate the public, health professionals, policy makers and funders on the public health issues associated with HCV.

**Objective 2:**           **Integrate HCV education, counseling, testing and referral into existing relevant programs that serve high-risk and other vulnerable populations.**

### **Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Identify appropriate and effective science based prevention and risk reduction strategies from national sources and other states to prioritize interventions.
2. Develop or adapt existing HCV prevention curricula for local health department staff and coordinate staff training (train the trainers).
3. Develop or adapt HCV procedures and protocols for program screening and counseling personnel similar to the HIV model described in the AIDS Omnibus Bill.
4. Incorporate and provide training on the inclusion of HCV prevention messages and interventions into existing HIV/AIDS, STD, Hepatitis B, occupational safety and health, harm reduction, substance abuse, juvenile detention centers, and mental health programs whenever possible and appropriate.

*During years two and three, DOH and its partners should collaborate to:*

5. Incorporate such messages into programs that deal with veteran populations not accessing services from the Veterans Administration, and persons incarcerated in and being released from correctional institutions.

**Objective 3:            Develop alternative sources for the delivery of HCV primary prevention services for high-risk populations not served by HIV/AIDS, STD, and substance abuse programs.**

**Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Conduct a needs assessment to determine what prevention services are available, what services are needed for an effective intervention, and what areas/regions may have a higher priority for services.

*During years two and three, DOH and its partners should collaborate to:*

2. Provide training for community-based service providers that reach the high-risk and at-risk populations to assure that their counseling and referral services provide complete, current, and accurate information.
3. Work with relevant agencies to expand substance abuse treatment capacity for injection drug users.

**Objective 4:            Strengthen collaboration among state agencies and between state and local governmental agencies and private sector stakeholders to prevent the spread of HCV.**

**Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Identify existing prevention services and determine gaps. Convene an inter/cross agency work group.
2. Define roles and identify funding streams and legal or other barriers that prevent state and local governmental agencies and private sector agencies from coordinating and conducting prevention efforts.
3. Integrate HCV prevention efforts across state, local governmental agencies and private sector agencies through memoranda of understanding (MOU), contracts, or other arrangements.
4. Share resources to deliver effective, coordinated, and resource-efficient HCV prevention efforts.

**Objective 5:            Evaluate the effectiveness of HCV prevention programs.****Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Identify key evaluation questions and standard measures of program effectiveness.

*During years two and three, DOH and its partners should collaborate to:*

2. Provide guidance on how to evaluate primary prevention programs for HCV.
3. Provide technical support and training for contractors and health program staff so that they can evaluate HCV primary prevention activities.
4. Evaluate effectiveness of prevention strategies, using appropriate process and outcome methods.
5. Prepare and distribute reports resulting from the evaluation of HCV primary prevention activities to local health departments, community-based organizations, and other relevant agencies providing HCV prevention activities.

## **Management**

<b>Goal:</b>	Identify effective, accessible, and affordable case management and treatment services to prevent or limit the progression and complications of HCV infection and improve the affected individual's quality of life.
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**Objective 1:**            **Establish and implement a comprehensive care structure for the management of HCV. This structure should include HCV testing, treatment, disease management, patient education, and referrals to substance abuse treatment (including methadone treatment centers) and other related services for all high-risk individuals receiving services through local drug treatment and needle exchange programs, HIV/AIDS/STD programs, local health departments, correctional settings, veteran services, community health, mental health, and/or other relevant agencies.**

### **Action Steps:**

*During years one, two, and three, DOH and its partners should collaborate to:*

1. Implement and activate a statewide telephone “clearinghouse” for access to HCV disease information and referrals to appropriate resources.
2. Integrate HCV testing/referrals into local drug treatment and needle exchange programs, HIV/AIDS/STD programs, local health departments, correctional settings, veteran services, community health, mental health, and/or other relevant agencies.

*During years two and three, DOH and its partners should collaborate to:*

3. Include Hepatitis A (HAV) and Hepatitis B (HBV) testing, vaccinations, and appropriate medical care to high-risk individuals through local drug treatment and needle exchange programs, HIV/AIDS/STD programs, local health departments, correctional settings, veteran services, community health, mental health, and/or other relevant agencies.

**Objective 2:**            **Offer education and training opportunities on long-term clinical management of HCV to physicians, nurse practitioners, registered nurses and allied health professionals.**

**Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Investigate the opportunity to integrate HCV, HIV, STD, and infectious disease education for providers.

*During year two, DOH and its partners should collaborate to:*

2. Work with various health professional organizations/associations to identify professionals who have competency in HCV and make that information available through statewide telephone clearinghouse.

*During years one, two, and three, DOH and its partners should collaborate to:*

3. Ensure multiple means of access, including web based training and education for providers.

**Objective 3:            Offer patients and their families education (prevention, management and transmission) about living with HCV.**

**Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Develop a brochure and a web page on prevention, management, and transmission of HCV for families and patients statewide.

*During year two and on-going, DOH and its partners should collaborate to:*

2. Ensure the brochure and web page are revised in keeping with current information.

**Objective 4:            Assure continuity of care for HCV patients who are transitioning between incarceration and the community.**

**Action Steps:**

*During year two, DOH and its partners should collaborate to:*

1. Design a system for the transition of HCV patients from incarceration to the community health system, from the community to incarceration, and from one correctional facility to another.

*During year three, DOH and its partners should collaborate to:*

2. Train correctional facilities staff and community health systems on how to implement the HCV transition system (from incarceration to community and community to incarceration) to allow a seamless continuity of care and support for HCV patients.

**Objective 5:                Research and identify a comprehensive model for an evidence-based process for prevention and management of HCV that is based on existing national recommendations and guidelines.**

**Action Steps:**

*During years one and two, DOH and its partners should collaborate to:*

1. Evaluate the inclusion of protocols into disease management practice that are evidenced-based to meet the goals of the legislation for the secondary prevention and management of HCV.
2. Convene a panel to review protocols for the secondary prevention and management of HCV.

*During years one, two, and three, DOH and its partners should collaborate to:*

3. Make recommendations to adopt protocols for the secondary prevention and management of HCV.

*During year three, DOH and its partners should collaborate to:*

4. Distribute adopted protocols to licensed health and health-related professionals for the management of HCV patient care.
5. Determine the applicability of the evidence-based model to other diseases.

*Upon completion of the recommendations, DOH and its partners should collaborate to:*

6. Review recommendations on an annual basis or as needed.

## **Funding**

<b>Goal:</b>	Develop strategies for providing adequate, sustainable resources for funding the implementation and maintenance of Washington State Hepatitis C Strategic Plan recommendations developed by the Advisory Committee.
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**Objective 1:** Utilize existing resources to establish a framework to implement the elements of the plan that can be funded within those existing resources.

### **Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Catalog current aspects of the plan that are being conducted by various stakeholder groups throughout the state.
2. Identify ways to integrate hepatitis C plan elements into existing programs and efforts.
3. Identify key organizations to partner or collaborate with and possibly share resources to ensure support for plan implementation.
4. Ensure that providers and consumers are aware of existing resources for education, testing, treatment, and other needs by developing a resource database that is accessible via the Internet (this information should also be available to providers & stakeholder groups to disseminate to the public who may not have access to the Internet).
5. Actively seek sustained funding from federal, state, and local sources in order to implement this state plan.

**Objective 2:** Identify and pursue options for in-kind donations, services, and materials from private and public sources.

### **Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Identify ways in which existing resources, including providers with particular expertise, may assist with education efforts, outreach, and training.
2. Identify resources for obtaining, distributing, and promoting educational and awareness materials.
3. Identify centers of excellence that can be used as resources for various aspects of the plan.

**Objective 3: Identify and pursue public (local, state and/or federal) grant and funding opportunities.**

**Action Steps:**

*During year one, DOH and its partners should collaborate to:*

1. Research currently available federal grant funds that can be related to hepatitis C.
2. Research how initial state funding was established for the AIDS Omnibus Bill in order to explore the possibility of a similar approach for hepatitis C.
3. Explore the potential for leveraging changes within Ryan White funding that would include the medical management of HCV/HIV co-infection.
4. Identify resources from within stakeholder groups to develop and submit grant proposals.
5. Explore the possibility of seeking state funding for prioritized activities within the state plan.

*During years one, two, and three, DOH and its partners should collaborate to:*

6. Actively track and support federal HCV legislation.

**Objective 4: Identify and pursue potential funding from both Hepatitis specific and non-Hepatitis specific private foundations / organizations.**

**Action Steps:**

*During years one, two, and three, DOH and its partners should collaborate to:*

1. Utilize grant development to establish a position that will support both educational aspects of the hepatitis C plan and fund raising efforts.
2. Research and pursue funding opportunities from private non-profit organizations.
3. Target foundations that focus on specific aspects of the plan, such as education or treatment.
4. Explore the possibility of collaborating with pharmaceutical companies and other for profit health organizations to support various aspects of the plan.
5. Approach private industry regarding partnering with the public sector to support various aspects of the plan.

6. Identify resources from within stakeholder groups to pursue private funds to support various aspects of the plan.

## **Conclusion**

Hepatitis C (HCV) is one of Washington State's major public health problems. Effective education and prevention strategies are essential to reduce the number of new cases, the overall prevalence of disease and the long-term health effects of this potentially life-threatening virus.

In recognition of the need to address HCV, Substitute Senate Bill 5039 (SSB 5039) was passed during the 2003 legislative session. It mandated the development of a state plan to address education, prevention, and management of HCV in our state. However, no state funds were appropriated for implementation of this plan. In their recommendations, the Advisory Committee (see page 131 under "Funding") advocates that both state and federal funds be sought in order to implement this plan.

The action steps to be implemented under this plan were prioritized using a three-year implementation plan, designated to begin in January 2004. In addition to focusing on the implementation of year one action steps, DOH will develop cost implementation estimates for the full implementation of the strategic plan during the first year of the plan's implementation phase. In addition, DOH and its partners will also begin seeking private and federal funding sources during year one. SSB 5039 requires DOH to provide the legislature with an update and progress report for the state Strategic Plan on December 1, 2004. This report will include an estimated range of costs for fully implementing the plan.

The need to move forward in a direction that fully recognizes and addresses the impacts of HCV is overdue. The development and implementation of this plan is intended to put forth a comprehensive approach to reduce the impact of hepatitis C in Washington State. The majority of the Advisory Committee's "recommendations" depend on the ability of the DOH and its partners to facilitate the "action steps". The success of this plan will involve a coordinated, collaborative, and sustained approach to the prevention, education, and management of HCV by many sectors around the state. Partnerships between DOH and stakeholder groups, including those who helped to develop this plan, will be necessary for full implementation.

## **APPENDIX A:**

### **Substitute Senate Bill 5039**

**SUBSTITUTE SENATE BILL 5039**

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**AS AMENDED BY THE HOUSE**

**Passed Legislature - 2003 Regular Session**

**State of Washington**

**58th Legislature**

**2003 Regular Session**

**By** Senate Committee on Health & Long-Term Care (originally sponsored by Senators Kastama, Thibaudeau and Kohl-Welles)

READ FIRST TIME 02/28/03.

AN ACT Relating to hepatitis C; amending RCW 49.60.172 and 49.60.174; adding a new section to chapter 70.54 RCW; adding a new section to chapter 50.20 RCW; creating a new section; and providing an expiration date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

**NEW SECTION.** **Sec. 1.** A new section is added to chapter 70.54 RCW to read as follows:

(1) The secretary of health shall design a state plan for education efforts concerning hepatitis C and the prevention and management of the disease by January 1, 2004. In developing the plan, the secretary shall consult with:

- (a) The public;
- (b) Patient groups and organizations;
- (c) Relevant state agencies that have functions that involve hepatitis C or provide services to persons with hepatitis C;
- (d) Local health departments;
- (e) Public health and clinical laboratories;
- (f) Providers and suppliers of services to persons with hepatitis C;
- (g) Research scientists;
- (h) The University of Washington; and

(i) Relevant health care associations.

(2) The plan shall include implementation recommendations in the following areas:

(a) Hepatitis C virus prevention and treatment strategies for groups at risk for hepatitis C with an emphasis towards those groups that are disproportionately affected by hepatitis C, including persons infected with HIV, veterans, racial or ethnic minorities that suffer a higher incidence of hepatitis C, and persons who engage in high-risk behavior, such as intravenous drug use;

(b) Educational programs to promote public awareness about hepatitis C and knowledge about risk factors, the value of early detection, screening, services, and available treatment options for hepatitis C, which may be incorporated in public awareness programs concerning bloodborne infections;

(c) Education curricula for appropriate health and health-related providers covered by the uniform disciplinary act, chapter 18.130 RCW;

(d) Training courses for persons providing hepatitis C counseling, public health clinic staff, and any other appropriate provider, which shall focus on disease prevention, early detection, and intervention;

(e) Capacity for voluntary hepatitis C testing programs to be performed at facilities providing voluntary HIV testing under chapter 70.24 RCW;

(f) A comprehensive model for an evidence-based process for the prevention and management of hepatitis C that is applicable to other diseases; and

(g) Sources and availability of funding to implement the plan.

(3) The secretary of health shall develop the state plan described in subsections (1) and (2) of this section only to the extent that, and for as long as, federal or private funds are available for that purpose, including grants. Funding for this act shall not come from state sources.

(4) The board of health may adopt rules necessary to implement subsection (2)(b) of this section.

(5) The secretary of health shall submit the completed state plan to the legislature by January 1, 2004. After the initial state plan is submitted, the department shall update the state plan biennially and shall submit the plan to the governor and make it available to other interested parties. The update and progress reports are due December 1, 2004, and every two years thereafter.

(6) The state plan recommendations described in subsection (2)(b) of this section shall be implemented by the secretary of health only to the extent that, and for as long as, federal or private funds are available for that purpose, including grants.

(7) This section expires June 30, 2007.

**Sec. 2.** RCW 49.60.172 and 1988 c 206 s 903 are each amended to read as follows:

(1) No person may require an individual to take an HIV test, as defined in chapter 70.24 RCW, or hepatitis C test, as a condition of hiring, promotion, or continued employment unless the absence of HIV or hepatitis C infection is a bona fide occupational qualification for the job in question.

(2) No person may discharge or fail or refuse to hire any individual, or segregate or classify any individual in any way which would deprive or tend to deprive that individual of employment opportunities or adversely affect his or her status as an employee, or otherwise discriminate against any individual with respect to compensation, terms, conditions, or privileges of employment on the basis of the results of an HIV test or hepatitis C test unless the absence of HIV or hepatitis C infection is a bona fide occupational qualification of the job in question.

(3) The absence of HIV or hepatitis C infection as a bona fide occupational qualification exists when performance of a particular job can be shown to present a significant risk, as defined by the board of health by rule, of transmitting HIV or hepatitis C infection to other persons, and there exists no means of eliminating the risk by restructuring the job.

(4) For the purpose of this chapter, any person who is actually infected with HIV or hepatitis C, but is not disabled as a result of the infection, shall not be eligible for any benefits under the affirmative action provisions of chapter 49.74 RCW solely on the basis of such infection.

(5) Employers are immune from civil action for damages arising out of transmission of HIV or hepatitis C to employees or to members of the public unless such transmission occurs as a result of the employer's gross negligence.

**Sec. 3.** RCW 49.60.174 and 1997 c 271 s 6 are each amended to read as follows:

(1) For the purposes of determining whether an unfair practice under this chapter has occurred, claims of discrimination based on actual or perceived HIV or hepatitis C infection shall be evaluated in the same manner as other claims of discrimination based on sensory, mental, or physical disability; or the use of a trained dog guide or service animal by a disabled person.

(2) Subsection (1) of this section shall not apply to transactions with insurance entities, health service contractors, or health maintenance organizations subject to RCW 49.60.030(1)(e) or 49.60.178 to prohibit fair discrimination on the basis of actual HIV or actual hepatitis C infection status when bona fide statistical differences in risk or exposure have been substantiated.

(3) For the purposes of this chapter~~((;))~~:

(a) "HIV" means the human immunodeficiency virus, and includes all HIV and HIV-related viruses which damage the cellular branch of the human immune system and leave the infected person immunodeficient; and

(b) "Hepatitis C" means the hepatitis C virus of any genotype.

**NEW SECTION. Sec. 4.** A new section is added to chapter 50.20 RCW to read as follows:

(1) Credentialed health care professionals listed in RCW 18.130.040 shall be deemed to be dislocated workers for the purpose of commissioner approval of training under RCW 50.20.043 if they are unemployed as a result of contracting hepatitis C in the course of employment and are unable to continue to work in their profession because of a significant risk that such work would pose to other persons and that risk cannot be eliminated.

(2) For purposes of subsection (1) of this section, a health care professional who was employed on a full-time basis in their profession shall be presumed to have contracted hepatitis C in the course of employment. This presumption may be rebutted by a preponderance of the evidence that demonstrates that the health care professional contracted hepatitis C as a result of activities or circumstances not related to employment.

**NEW SECTION. Sec. 5.** Section 1 of this act does not create a private right of action.

Passed by the Senate April 27, 2003.

Passed by the House April 23, 2003.

Approved by the Governor May 14, 2003.

Filed in Office of Secretary of State May 14, 2003.

## **APPENDIX B:**

### **Health Professionals Covered Under The Uniform Disciplinary Act (UDA)**

Chapter 18.130 RCW

**RCW**  
**Intent.**

**18.130.010**

It is the intent of the legislature to strengthen and consolidate disciplinary and licensure procedures for the licensed health and health-related professions and businesses by providing a uniform disciplinary act with standardized procedures for the licensure of health care professionals and the enforcement of laws the purpose of which is to assure the public of the adequacy of professional competence and conduct in the healing arts.

It is also the intent of the legislature that all health and health-related professions newly credentialed by the state come under the Uniform Disciplinary Act.

Further, the legislature declares that the addition of public members on all health care commissions and boards can give both the state and the public, which it has a statutory responsibility to protect, assurances of accountability and confidence in the various practices of health care.

[1994 sp.s. c 9 § 601; 1991 c 332 § 1; 1986 c 259 § 1; 1984 c 279 § 1.]

**RCW**

**18.130.040**

**Application to certain professions -- Authority of secretary -- Grant or denial of licenses -- Procedural rules. (*Effective until July 1, 2003.*)**

(1) This chapter applies only to the secretary and the boards and commissions having jurisdiction in relation to the professions licensed under the chapters specified in this section. This chapter does not apply to any business or profession not licensed under the chapters specified in this section.

- (2)(a) The secretary has authority under this chapter in relation to the following professions:
- (i) Dispensing opticians licensed under chapter 18.34 RCW;
  - (ii) Naturopaths licensed under chapter 18.36A RCW;
  - (iii) Midwives licensed under chapter 18.50 RCW;
  - (iv) Ocularists licensed under chapter 18.55 RCW;
  - (v) Massage operators and businesses licensed under chapter 18.108 RCW;
  - (vi) Dental hygienists licensed under chapter 18.29 RCW;
  - (vii) Acupuncturists licensed under chapter 18.06 RCW;

- (viii) Radiologic technologists certified and X-ray technicians registered under chapter 18.84 RCW;
- (ix) Respiratory care practitioners licensed under chapter 18.89 RCW;
- (x) Persons registered under chapter 18.19 RCW;
- (xi) Persons licensed as mental health counselors, marriage and family therapists, and social workers under chapter 18.225 RCW;
- (xii) Persons registered as nursing pool operators under chapter 18.52C RCW;
- (xiii) Nursing assistants registered or certified under chapter 18.88A RCW;
- (xiv) Health care assistants certified under chapter 18.135 RCW;
- (xv) Dietitians and nutritionists certified under chapter 18.138 RCW;
- (xvi) Chemical dependency professionals certified under chapter 18.205 RCW;
- (xvii) Sex offender treatment providers certified under chapter 18.155 RCW;
- (xviii) Persons licensed and certified under chapter 18.73 RCW or RCW 18.71.205;
- (xix) Denturists licensed under chapter 18.30 RCW;
- (xx) Orthotists and prosthetists licensed under chapter 18.200 RCW; and
- (xxi) Surgical technologists registered under chapter 18.215 RCW.
- (b) The boards and commissions having authority under this chapter are as follows:
  - (i) The podiatric medical board as established in chapter 18.22 RCW;
  - (ii) The chiropractic quality assurance commission as established in chapter 18.25 RCW;
  - (iii) The dental quality assurance commission as established in chapter 18.32 RCW;
  - (iv) The board of hearing and speech as established in chapter 18.35 RCW;
  - (v) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;
  - (vi) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

- (vii) The board of osteopathic medicine and surgery as established in chapter 18.57 RCW governing licenses issued under chapters 18.57 and 18.57A RCW;
- (viii) The board of pharmacy as established in chapter 18.64 RCW governing licenses issued under chapters 18.64 and 18.64A RCW;
- (ix) The medical quality assurance commission as established in chapter 18.71 RCW governing licenses and registrations issued under chapters 18.71 and 18.71A RCW;
- (x) The board of physical therapy as established in chapter 18.74 RCW;
- (xi) The board of occupational therapy practice as established in chapter 18.59 RCW;
- (xii) The nursing care quality assurance commission as established in chapter 18.79 RCW governing licenses issued under that chapter;
- (xiii) The examining board of psychology and its disciplinary committee as established in chapter 18.83 RCW; and
- (xiv) The veterinary board of governors as established in chapter 18.92 RCW.

(3) In addition to the authority to discipline license holders, the disciplining authority has the authority to grant or deny licenses based on the conditions and criteria established in this chapter and the chapters specified in subsection (2) of this section. This chapter also governs any investigation, hearing, or proceeding relating to denial of licensure or issuance of a license conditioned on the applicant's compliance with an order entered pursuant to RCW [18.130.160](#) by the disciplining authority.

(4) All disciplining authorities shall adopt procedures to ensure substantially consistent application of this chapter, the Uniform Disciplinary Act, among the disciplining authorities listed in subsection (2) of this section.

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